REFERRAL INFORMATION FORM

For scheduling please contact: _____ **Phone:** _____

Date of Referral: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ E-mail: _____

Would you like to receive Appointment Reminder Phone Calls or Texts? ❑ Yes ❑ No Which do you prefer? ❑Call ❑Text

Preferred Time to Call/Text? _____AM / PM

Preferred Phone Number to receive Reminder Phone Call? _____

Marital Status: _____

Race: ❑ White ❑ Black or African American ❑ Asian ❑ Native Hawaiian ❑ American Indian

Ethnicity: ❑ Hispanic ❑ Non-Hispanic Language Spoken: ❑ English ❑ Other: _____

Sexual Orientation: ❑ Straight ❑ Gay/Lesbian ❑ Bisexual ❑ Don't know ❑ Something Else ❑ Choose not to disclose

Gender Identity ❑ M ❑ F ❑ Transgender (M→F) ❑ Transgender (F→M) ❑ Other

Social Background ❑ Veteran ❑ Migrant ❑ Seasonal ❑ Homeless ❑ Public Housing ❑N/A

Medical Providers:

Primary Care Physician: _____ Phone #: _____

Medical Hx/ Diagnosis: _____

Allergies: _____ Special Alerts: _____

Insurance Information:

SS#: _____-_____-_____ Medicare #: _____ Medicaid #: _____

❑ No Insurance Other Insurance/Type: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

Employer: _____

Address: _____City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Pharmacy: _____

Address: _____City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Family and Guardian Information:

Spouse's Name (Last, First): _____ Cell #: _____

Father's Name (Last, First): _____ Cell #: _____

Mother's Name (Last, First): _____ Cell #: _____

Parents' Address: _____

Home Phone #: _____ Business #: _____ Cell #: _____

Guardian Name (if different from parents): _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____

Address: _____

Phone #: _____ Cell #: _____

Services Requested (Check all that apply):

❑ Primary Care ❑ Women's Health (GYN) ❑ Psychiatry ❑ Neurology ❑ Endocrinology
❑ Dermatology ❑ Podiatry

If applicable, please complete the following:

Primary Diagnosis: _____ Level of disability, if applicable _____

Type of Residence: ❑ Family ❑ ICF ❑ IRA ❑ Other: _____ Agency:_____

Residence Manager_____ Phone #: _____ Email: _____

Residence Nurse: _____ Phone #: _____ Email: _____

Residence Fax: _____

Case Manager: _____ Current ISP? ❑ Yes ❑ No

Agency: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ E-mail: _____

Day program/Employer: _____ Is this a Day Treatment Program? ❑ Yes ❑ No

Address: _____City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Program Director: _____ Phone: _____ Email: _____

FOR OFFICE USE ONLY

This referral was received on _____ by _____